### GENERAL INFORMATION:

### **QUICK TIPS!**

- Form should be completed by professional staff most familiar with the individual being screened such as nurses (LPN or RN), discharge planners, social workers, etc.
- Use information readily available in the medical records. It is not necessary to do an in-depth interview with the individual, their family or representative.
- If no information is available or a section does not apply, mark through the box/section with an "X" and state "N/A".
- Skip all shaded areas (areas specified for FHSC use).
- DO NOT COMPLETE OR SEND PAGE 2 UNLESS INDICATORS OF MI, AND/OR MR/RC ARE IDENTIFIED.
- Attach a physician's statement (can be written as an order, on a prescription note pad, etc.) for the sections described on Page 2, as required. See Provider Instructions.

The Level I Identification screening is required to be completed for all potential nursing facility residents, without exception and regardless of payment source, to identify individuals with indicators of serious mental illness (MI), mental retardation (MR), or related conditions (RC). The discharging facility/entity is required to complete and submit this form to First Health Services Corporation (FHSC), and must await the screening determination (verbal or written) from FHSC prior to discharging the individual to a Medicaid-certified nursing facility. If it is not known whether the individual has an existing PASRR determination, the requestor may submit the Nevada PASRR & LOC Screening Request form to FHSC to inquire about the existence of a prior screening.

If the individual has experienced a significant change in their physical or mental status, has been admitted to a NF without a Level I, or a previous Level II Categorical Determination was time-limited and requires updating, the Level I is required to be completed by the nursing facility to request completion of a PASRR Level II screening.

Forms may be downloaded from the FHSC web site. To submit the forms and any required attachments (see page 2, Section VII), fax to FHSC (866) 480-9903. Acute care facility requests are processed within one (1) business day; all other requests are processed within three (3) business days.

#### FORM COMPLETION INSTRUCTIONS:

#### Page 1 of 2

The majority of screenings require only the first page (page 1 of 2) of information to be completed. The second page (page 2 of 2) of information relates to those individuals who are determined to have indicators of MI, MR, or RC.

Complete Date Submitted to FHSC to document the date the request for screening was submitted to FHSC. Please note: the date the screening form and all other required information was received at FHSC will be the date the request is valid. Check or type an "X" for Initial if this is the first time the individual has had a Level I Identification Screening or to indicate Update if this is an updated screening.

Complete the Patient's/Individual's Name (last, first). Complete the home address to indicate where the individual usually resides. This address should be a physical address in the event an on-site review is necessary. List any known diagnoses that may be pertinent to determine the presence of any mental illness, mental retardation or related conditions, or which may qualify the individual for a categorical determination.

Provide the Legal Representative's name, if indicated.

Complete the Provider ID#. This is the number issued by Nevada Medicaid to a provider.

Complete Requesting Facility to indicate the name of the facility/entity requesting the screening. Include the mailing address, telephone number, fax number and the name of the requestor. The name of the requestor should be the name of the person FHSC may contact if they have any questions or need additional information in order to complete the screening.

Complete the Social Security (SS) number, the Medicaid Billing number if the individual is eligible for Medicaid benefits (or N/A if not eligible), Sex (M or F), Date of Birth (DOB), Payment Source (indicate Medicaid if Medicaid eligible even if currently covered by another primary payment source, Private if private pay, etc.) and their Marital Status.

If currently residing in a nursing facility, indicate the Admit Date.

If awaiting placement in a nursing facility, provide the Admitting Facility name, address, a contact name, telephone number and fax number of the potential facility if the receiving facility is known. If contacting multiple facilities, please indicate "UK" for unknown.

Indicate the Patient's Current Location by placing an "x" in Home, Acute In-Patient, ER (emergency room), Acute Observation Bed, NF (nursing facility), Rehabilitation Hospital/Unit, or Other. If Other, indicate where they are located.

#### SECTION I: MENTAL ILLNESS (MI) SCREENING

Place an "X" in all boxes for diagnoses that pertain to the individual screened. If the individual is diagnosed with a psychiatric condition that is not listed, use Other to describe the condition/diagnosis. Add specific information in the areas where it is requested.

List all psychiatric/psychotropic medications, including tranquilizers and antidepressants which the individual routinely receives. If the individual typically is prescribed a medication within that drug group and it has been temporarily discontinued (e.g., because he/she is in the hospital), that drug should be noted. Complete the Diagnosis/Purpose section to provide the reason the medication is prescribed.

<u>Psychiatric treatment more intense than outpatient received in past 2 years (MORE THAN ONCE)</u>. Complete this section by placing an "X" in any box that pertains. If a box is marked, include the dates of such services. Indicate any mental health/psychiatric intervention in which the individual has received in the past two (2) years. Inpatient psychiatric hospitalization refers to hospital treatment in a psychiatric facility or a general hospital psychiatric unit; partial hospitalization/day treatment refers to participation in a structured, outpatient group program of at least three (3) hours per day for a specified number of days per week; other refers to any alternative mental health/psychiatric services, to include psychiatric consultations, group therapy, individual therapy, etc.

Intervention to prevent hospitalizations. Indicate whether, in the absence of psychiatric treatment, the individual has been at risk for intense psychiatric treatment because of mental illness. The services/conditions included in this section refer to services/conditions which are typical of the seriously mental illness population as a result of the chronicity of the illness. Supportive living (assisted living, group home, supervised living, etc.) refers to settings designed or monitored by the mental health system as a result of the individual's symptomatology; housing intervention/legal intervention, refers to systemic intervention resulting from the individual's psychiatric status/condition; suicide attempt/other refers to any other conditions/symptoms which may have resulted from the individual's mental illness and therefore, put him/her at risk for psychiatric hospitalization (although such hospitalization may never have occurred).

If the requestor is unable to obtain this information from the sources readily available, and based on the individual's behavior, diagnosis and/or symptoms, such a history is suspected, the requestor should indicate that "no information is available", rather than responding "no" to the question regarding treatment history.

Role limitations in past 6 months due to mental illness. Each of the three (3) categories (3.A through 3.C) are to be rated according to their presence/absence within the past 6 months. Each of these sections should be rated according to the impact the mental illness (or psychiatric symptoms), if present, has on the evaluated issue and should not be rated with respect to the impact of a physical illness or diagnosis. If the individual presents with some of the symptoms/behavioral problems, not related to a physical condition, and he/she has no diagnosis of mental illness, the individual should still be rated.

<u>Interpersonal Relationships</u>. Circle (or type an "x" over) the F, O, or N to indicate: Frequently, Occasionally, or Never, respectively. Any behavioral/symptomatic conditions observed by the requestor, facility staff, and/or family which are not noted in the supplied listing, should be indicated in the space provided.

<u>Concentration/Task Limitations</u>. See instructions for Interpersonal Relationships (above). Indicate the frequency for all that apply and which are related to the individual's mental health status, not to physical condition. Provide any additional information in the notes area.

Significant problems adapting to typical changes within past six (6) months and due to MI. Indicate either "Y" for yes or "N" for no to all areas that pertain. This area addresses the individual's response to any recent lifestyle changes and whether that response may be indicative of or consistent with a serious mental illness. Provide any additional information in the notes area.

### SECTION II: MENTAL RETARDATION (MR) AND RELATED CONDITIONS (RC)

MR Diagnosis. Indicate either "Y" for yes or "N" for no to indicate whether the individual is diagnosed with mental retardation. Specify the level of retardation as mild, moderate, severe, or profound, if known. If this information is not available, indicate "UK" for unknown.

<u>Undiagnosed but suspected MR</u>. If the individual has not been diagnosed with mental retardation (but such a condition is suspected) or the requestor is uncertain as to whether or not such a diagnosis has been assigned (but suspects that it may be appropriate) the requestor should indicate "Y" to show MR is suspected. If MR Diagnosis was "Y", it will not be necessary to answer this section because the suspected diagnosis has already been confirmed.

<u>History of receipt of MR services</u>. If the individual has received services from a developmental disabilities program, or from other MR affiliates, indicate "Y" and specify the type(s) of service.

Occurrence before age 18. Check either "Y" or "N" to indicate if the MR diagnosis occurred before age 18.

Related Conditions (diagnoses) which impair intellectual functioning or adaptive behavior. This area, and the following two (2), determine whether the individual falls within the parameters of a condition related to mental retardation, "related conditions", meaning that an individual with such a condition may need treatment similar to that of a person with mental retardation. There are a number of diagnoses/conditions considered related, including those listed: Blindness, Deafness, Cerebral Palsy, Autism, complicated Epilepsy. Others include post encephalitis (prior to age 22), head trauma (prior to age 22), etc. If the requestor is uncertain about a diagnostic inclusion in this category, list any suspected related conditions in the space titled Other and FHSC clinical reviewers will make the determination.

<u>Substantial functional limitations in 3 or more of the following areas</u>: Check Y or N to indicate whether the diagnosis/condition has severely impacted the functional areas which are similar to the functional impact found with typical MR individuals.

Was the condition manifested before age 22? Was the identified condition congenital or developed at any time during the developmental period (e.g., head injury, encephalitis)? Individuals whose condition occurred prior to age 22 and who meet the criteria for 2 and 3 above, meet the definition for MR and/or RC.

If there were no indicators of MI in Section I or MR/RC in Section II, complete the name and professional title of the person completing the form at the bottom of page 1 and submit the form to FHSC for a screening determination. Due to the nature of the questions asked, this form should be completed by professional staff most familiar with the individual being screened such as nurses (LPN or RN), discharge planners, social workers, etc. Complete the Date the form was completed.

FHSC clinical reviewers will evaluate the information provided and issue a determination letter to the requestor.

STOP HERE IF THERE ARE NO INDICATORS OF MI, MR OR RC! Page 2 and the associated attachment requirements are only required when indicators of MI, MR or RC have been identified on page 1.

#### SECTION III: DEMENTIA

If the individual has indicators of either MI (Section I) or MR/RC (Section II), complete the Section III Dementia to determine whether the individual requires further screening or is not appropriate for Level II screening due to the dementia. If the dementia diagnosis is primary (implies that the symptoms of the dementia supercede symptoms of any concurrent psychiatric condition) to the MI diagnosis, no further screening would be needed.

<u>Does the individual have a primary diagnosis of dementia or Alzheimer's Disease?</u> This determines whether the individual has the condition and if it is primary. The physician should determine whether the dementing condition (if present) is primary, meaning that the dementia supercedes symptoms of any concurrent psychiatric symptoms or behaviors for MI or MR/RC.

<u>Does the individual have any other organic disorders?</u> This determines whether there is another organic condition for which the presenting symptoms/behaviors may be attributed.

<u>Is there evidence of undiagnosed dementia or other organic mental disorders?</u> Although the individual may not be diagnosed with dementia or a like disorder, this determines whether there are presenting symptoms consistent with such a diagnosis.

<u>Is there evidence of affective symptoms which may be confused with dementia?</u> This determines whether some of the presenting symptoms are affective (emotionally based) in nature, possibly indicating a potential for confusion between dementia and another psychiatric condition.

Attachment requirements are as follows: provide any corroborative information to affirm that the dementing condition exists and is the primary diagnosis. Attach a physician's statement

supporting 1) the diagnosis of Alzheimer's Disease, dementia or a related condition, and 2) that the Alzheimer's Disease, dementia or related condition is primary to the MI diagnosis.

If Alzheimer's Disease, dementia or related condition is primary to the MI diagnosis, the requestor may stop at this point and skip to Section VII.

#### SECTION IV: EXEMPTED HOSPITAL DISCHARGE

Individuals with indicators of MI or MR/RC who meet all of the specified criteria in this section are exempt from PASRR Level II screening for 30 days. The requestor may request an Exempted Hospital Discharge (EHD) when the individual meets all of the specified criteria:

- (1) Admission to the NF directly from an acute in-patient hospital after receiving acute in-patient care at the hospital;
- (2) Requires NF services for the condition he/she received care in the hospital; and
- (3) The attending physician has certified prior to NF admission that the individual will require less than 30 days of NF services.

The acute care services must have been acute in-patient and not emergency room, an observation bed, or a rehabilitation hospital/unit of the acute care facility. The requestor must obtain and submit a copy of the physician's certification that less than 30 days of nursing facility services are needed for the same condition which required hospitalization. This certification must be signed and dated prior to the admission to a nursing facility.

Attachment Requirement: Physician's statement indicating less than 30 days of nursing facility services are needed.

FHSC will limit this approval to 30 days from the date of the determination. If it is later determined by the physician that more than 30 days of NF services are needed, the NF requestor must obtain a completed screening by the 40<sup>th</sup> day of admission. The request for PASRR Level II screening must be made by the 25<sup>th</sup> day of admission to allow time for its completion.

#### PASRR LEVEL II CATEGORICAL DETERMINATIONS:

State and federal regulations allow advanced group categorical determinations in some circumstances. These determinations may be made if it is identified the individual requires the services of a nursing facility and does not need specialized services for the time period indicated. Complete this section if requesting a categorical determination.

#### SECTION V: Time-Limited Categorical Determinations

The following categories are time-limited. For A, C, and D, the request for PASRR Level II Individual Screening must be made in a time frame that allows its completion prior to the limitation date. There will be no Medicaid payment for days that lapse between a limitation date and the date the Level II Individual Evaluation has been completed.

- A. <u>Convalescent Care</u> from an acute physical illness which required hospitalization and does not meet all of the criteria for an Exempted Hospital Discharge. This group is limited to no more than 45 days. The PASRR Level II screening must be requested and completed prior to the limitation date.
- B. <u>Emergency Protective Services</u> is not to exceed 7 days. This group is limited to 7 days maximum.
- C. <u>Delirium</u> which precludes the ability to accurately diagnose is limited to 30 days maximum. The facility must request and obtain a completed PASRR Level II as soon as the delirium clears, but not to exceed 30 days.
- D. <u>Respite</u> is needed for in-home caregivers to whom the individual with MI, or MR/RC will return. This is limited to a maximum of 30 days.

If any of the above are indicated, the receiving facility must submit a new Level I to request a PASRR Level II Individual Evaluation ten (10) days prior to the limitation date, if the individual's stay is anticipated to exceed the limitation date.

Attachment Requirement: If any of the above categorical determinations are being requested, include the physician's statement to support either A, B, C, or D.

### SECTION VI: OTHER CATEGORICAL DETERMINATIONS

This category is not time-limited. However, if there is a significant change in the physical or mental status of the individual, a new screening may be required. The requestor should request the screening and identify those changes to FHSC clinical reviewers. They will determine whether to proceed with the screening.

As with time-limited categorical determinations, the individual must have a need for nursing facility services. Additionally, it is expected that due to the severity of illness, it is expected the individual would not benefit from specialized services.

IIF: <u>Terminal Illness</u>. If this category is requested, a physician's certification of life expectancy of six (6) months or less is required. See section VII.

IIG: <u>Severe Physical Illness</u>. This category is limited to the following illnesses: Coma, Ventilator Dependence, Functioning at brain stem level, or a diagnosis of Parkinson's Disease, Chronic Obstructive Pulmonary Disease (COPD), Huntington's Disease, Amyotrophic Lateral Sclerosis (ALS), or Congestive Heart Failure (CHF).

Attachment Requirement: A physician's statement supporting the requested categorical determination of either the terminal illness, or that the identified condition for severe physical illness is so severe that the individual is not expected to benefit from specialized services.

SECTION VII: REQUESTING PROVIDER TO COMPLETE.

<u>Mailing Information</u>. If there are indicators of MI, MR/RC from page 1, the requestor must provide the name and a valid mailing address for a legal representative (if applicable) and the attending physician.

If there are other sources of supporting documentation provided, check the box to alert FHSC of the attachments. If the requestor is asking for an Exempted Hospital Discharge, a physician's certification of a less than 30 day nursing facility stay must be attached/submitted. If the

requestor is asking for any categorical determination, a physician's statement (in whatever, format (orders, progress note, H&P, discharge summary, etc.) must be attached/submitted.

<u>Date form Completed</u>. This date must reflect the date form was completed, not the date of submission.

<u>Name and Professional Title of person completing form.</u> Due to the nature of the questions asked, this form should be completed by professional staff most familiar with the individual being screened such as nurses (LPN or RN), discharge planners, social workers, etc. Complete the name and professional title of the person completing and providing information for this screening.

Submit the form and any required attachments to FHSC via fax at 1-866-480-9903. Requestors must independently track submissions and obtain a verification of the fax transmission. Do not contact FHSC by telephone or fax to inquire on the status until the required time-frame for their processing has lapsed (i.e., one (1) business day if from an acute care facility, three (3) business days for all other requests). This includes inquires about whether FHSC received the request. This interferes with their ability to process determinations timely. Advanced discharge planning by the requestor is critical in order to receive determinations timely and to prevent delays in discharge.

FHSC clinical reviewers will evaluate the information provided and issue a determination letter to the requestor.